

MEDICAL RECORD REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

FLEXIBLE SIGMOIDOSCOPY WITH POSSIBLE BIOPSY AND/OR POLYPECTOMY

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the operation or procedure. I understand the nature of the operation or procedure to be the insertion of a flexible sigmoidoscope into the rectum, then advancing it to examine a portion of the colon (intestine). Biopsies (small pieces of tissue) may be taken for microscopic examination. Potential complications include perforation (a hole in the colon), bleeding requiring transfusion, infection, drug reaction, the need for surgery, or death,

which is to be performed by or under the direction of Dr. _____

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as may be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: none

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to dispose of. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel going training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation authorized personnel, subject to the following conditions:

- a. The name of the patient and his/her family is not used to identify said pictures.
- b. Said pictures be used only for purposes of medical/dental study or research.

C. SIGNATURES

1. **COUNSELING PHYSICIAN/DENTIST:** I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(Signature of Counseling Physician/Dentist)

2. **PATIENT:** I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)

(Signature of Patient)

(Date and Time)

3. **SPONSOR OR GUARDIAN:** (When patient is a minor or unable to give consent) I, _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)

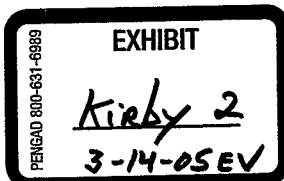
(Signature of Sponsor/Legal Guardian)

(Date and Time)

PATIENT'S IDENTIFICATION (For typed or written entries give Name—last, first, middle; grade, date; hospital or medical facility)

REGISTER NO.

WARD NO.



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General Services Administration &
Interagency Comm. on Medical Records
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